STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/15/11 Facility Number: 000222 Provider Number: 155329 AIM Number: 100274950 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Rosewalk Village at Indianapolis was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all areas not separated from the corridor. Battery operated smoke detection is provided in all the resident	K0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a Facility Revisit on or after 3/30/2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	sleeping rooms. The facility has a capacity of 182 and had a census of 168 at the time of this visit. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 03/22/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0029 SS=E	1. Based on observation and interview, the facility failed to ensure 1 of 5 doors serving hazardous areas such as mechanical rooms with natural gas fired water heaters are equipped with self closing devices on the doors. This deficient practice could affect any resident, staff or visitor in the vicinity of Mechanical Room #5. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:00 a.m. to 1:45 p.m. on 03/15/11, Mechanical Room # 5 contains two natural gas fired water heaters and is not equipped with a self closing device on the entry door. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the entry door to Mechanical Room # 5 is not equipped with a self closing device. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 5 hazardous areas such as mechanical rooms with natural gas fired water heaters are provided with smoke resistant partitions. This deficient practice could	K0029	K029 NFPA 101 Life Safety Code Standard **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** In-house maintenance installed a self-closing device on Mechanical room #5. In-house maintenance removed the wooden access panels and sealed the penetrations with two layers of 5/8" fire-rated sheetrock. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Maintenance made an inspection of all hazardous areas to ensure that all doors had self-closing devices and that there were no penetrations of the smoke barrier walls. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The maintenance director or their designee will make quarterly rounds and as needed rounds to ensure that there are door closers and no penetrations of walls	03/30/2011

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	affect any resident, staff or visitor in the vicinity of Mechanical Room # 1. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:00 a.m. to 1:45 p.m. on 03/15/11, Mechanical Room # 1 contains two natural gas fired water heaters. The rear wall of Mechanical Room # 1 has two wooden hinged doors each measuring one foot square which are not smoke resistant and provide access to the adjoining Nurses Supply room. Based on interview at the time of observation, the Maintenance Supervisor stated he was unaware of the purpose of each hinged door and acknowledged the two square wooden hinged doors are not smoke resistant. 3.1-19(b)		in each hazardous area rooms. The executive director will periodically inspect hazardous rooms for compliance on daily rounds. The maintenance director will report results of inspection quarterly to the CQI committee. The CQI Committee will review results quarterly to maintain compliance.	

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K0050 SS=F	Based on record review and interview, the facility failed to ensure 1 of 4 second shift fire drills included the transmission of a fire alarm signal. LSC 19.7.1.2 requires fire drills in health care occupancies to include the transmission of the fire alarm signal. This deficient practice affects all occupants in the facility including residents, staff and visitors. Findings include: Based on review of "Monthly Fire Drill Report" documentation with the Maintenance Supervisor from 9:25 a.m. to 11:00 a.m. on 03/15/11, the second shift fire drill conducted at 7:35 p.m. on 12/03/10 did not include transmission of the fire alarm signal. The 12/03/10 fire drill report stated "alarm was not physically activated." Based on interview at the time of record review, the Maintenance Supervisor stated the facility activates the fire alarm system each time a fire drill is conducted but acknowledged the 12/03/10 fire drill did not include the transmission of the fire alarm signal. 3.1-19(b)	K0050	**K050 NFPA 101 Life Safety Code Standard** **What corrective action(s) will be taken for those residents found to have been affected by the alleged deficient practice?** The Executive Director has rein-serviced the maintenance director regarding transmission of the fire alarm signal quarterly on each shift except for drills conducted between the hours of 9 pm and 6 am. **How will you identify other residents having the potential to be affected by the same alleged deficient practice, and what corrective action will be taken.** All residents have the potential to be affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The maintenance director has been rein-serviced regarding requirements for transmission of the fire alarm signal. The maintenance director will transmit the alarm on each shift quarterly except for drills conducted between the hours of 9 pm and 6 am. The maintenance director or their designee will log the transmission of the alarm signal on the monthly fire drill report. The maintenance director or their designee will review the fire drill report with the executive director monthly.	03/30/2011

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The maintenance director or their designee will review the fire drill report with the executive director monthly to show the documentation of transmission of the audible alarm. The maintenance director or their designee will report results to the CQI committee. CQI Committee will review testing results monthly for 3 months and quarterly thereafter.	

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K0104 SS=E	Based on record review, observation and interview; the facility failed to properly test and maintain smoke dampers in accordance with LSC Section 8.3.5 and NFPA 90A, 1998 Edition. NFPA 90A Section 3-4.7. requires at least every 4 years, all dampers be operated to verify they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary. This deficient practice could affect all residents, staff and visitors in the Therapy Gym if smoke dampers did not operate properly during a fire. Findings include: Based on record review and interview with the Maintenance Supervisor from 9:25 a.m. to 11:00 a.m. on 03/15/11, maintenance records for smoke dampers were not available for review. Based on observation with the Maintenance Supervisor during a tour of the facility from 11:00 a.m. to 1:45 p.m. on 03/15/11, eight smoke dampers were observed in the ceiling ductwork in the Therapy Gym. No other smoke dampers were observed in the facility. Based on interview at the time of observation, the Maintenance Supervisor acknowledged there is no documentation of smoke damper testing within the last four years.	K0104	**K104 NFPA 101 Life Safety Code Standard** **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** An outside contractor has made a thorough inspection of the facility to identify all smoke dampers and has performed the proper test and maintenance on all Smoke dampers; operating each to verify that they fully close and that all moving parts are lubricated. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken?** All residents have the potential to be affected by this alleged deficient practice **What measures will be put into place or what systemic changes will you make to ensure deficient practice does not recur?** Maintenance director has placed on preventative maintenance calendar to schedule the testing of the smoke dampers at least once every four years. An outside contractor has set up a schedule of maintenance and testing to be performed every four years on all smoke dampers. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality**	03/30/2011

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	3.1-19(b)		**assurance program will be put into place?** The CQI Committee will review results of testing and maintenance of the smoke dampers and will review the need for testing on an annual basis to ensure testing and maintenance are performed at least every four years.	

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K0130 SS=E	Based on observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect residents, staff and visitors in the Main Dining Room. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:00 a.m. to 1:45 p.m. on 03/15/11, there is a rolling fire door protecting the opening from the kitchen to the Main Dining Room without an	K0130	**K130 NFPA 101 Miscellaneous** **What corrective action(s) will be taken for those residents found to have been affected by the alleged deficient practice?** An outside contractor has inspected and tested the rolling fire door to check for proper operation and full closure. The release mechanism was reset in accordance with the manufacturer's instructions. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance director has placed on preventative maintenance calendar to schedule an annual test and inspection of the rolling fire door. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The CQI Committee will review results of testing and maintenance of the rolling fire door and will review the testing on an annual basis to ensure testing and maintenance is performed at least annually.	03/30/2011

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	attached inspection tag. The Main Dining Room is open to the corridor. Based on interview at the time of observation, the Maintenance Supervisor stated there is no annual inspection or test of the vertical rolling fire door to check for proper operation and full closure. 3.1-19(b)			

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K0143 SS=E	Based on observation and interview, the facility failed to ensure 2 of 2 areas used for the transferring of oxygen was separated from any portion of a facility wherein residents are housed, examined, or treated by a fire barrier of 1 hour fire resistive construction. This deficient practice could affect all residents, staff and visitors in the vicinity of resident Room 100 and resident Room 111. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:00 a.m. to 1:45 p.m. on 03/15/11, Room 100 and Room 111 each had one stationary liquid oxygen storage canister in a resident room with a nonrated door and with a nonrated ceiling and walls. Based on interview with the RN Unit Manager at the time of observation, the RN Unit Manager stated each resident was under hospice care administered by a contractor who provides the stationary liquid oxygen canisters utilized in each of these two rooms and transfills oxygen to portable canisters in these resident rooms. The Maintenance Supervisor acknowledged the liquid oxygen canisters used for transfilling oxygen in Room 100 and Room 111 are in nonrated resident	K0143	**K143 NFPA 101 Life Safety Code Standard** **What corrective action(s) will be taken for those found to have been affected by the alleged deficient practice?** The stationary liquid oxygen containers have been removed from rooms 100 and 111. Maintenance inspected all rooms to ensure that there were no additional liquid oxygen containers in non-rated rooms. **How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. **What measure will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Both the Hospice company and the Oxygen company were notified that no liquid oxygen containers could be stored in non-rated rooms and that no transfilling of oxygen canisters can be performed in non-rated rooms. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?**	03/30/2011

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	sleeping rooms. 3.1-19(b)		The maintenance director or their designee will monitor for compliance during monthly and routine rounds. The executive director will monitor for compliance during daily rounds. Results of monthly maintenance rounds will be reviewed by the CQI Committee monthly for 3 months and quarterly thereafter.	